FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011551

Facility Name: Medina Nursing Center

Address: P.O. Box 538 (Number) Durand (City) 61024 (Zip Code)

County: Winnebago

Telephone Number: (815) 248-2151 **Fax #** (815) 248-2771

IDPA ID Number: 366125769001

Date of Initial License for Current Owners: 05/18/65

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Chuck Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Holgeir Oksnevad
(Title) Administrator

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	92	0	1,608	1,700	8
9	SNF/PED					9
10	ICF	19,583	7,204		26,787	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,675	7,204	1,608	28,487	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.69%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 89 and days of care provided 1,608

Medicare Intermediary Mutual Of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	199,122	25,722	5,505	230,349		230,349		230,349			1
2	Food Purchase		179,736		179,736		179,736	(9,966)	169,770			2
3	Housekeeping	71,676	19,919		91,595		91,595		91,595			3
4	Laundry	65,383	14,350		79,733		79,733	(3,882)	75,851			4
5	Heat and Other Utilities			67,734	67,734		67,734		67,734			5
6	Maintenance	44,856	12,135	27,927	84,918		84,918		84,918			6
7	Other (specify):*											7
8	**TOTAL General Services**	381,037	251,862	101,166	734,065		734,065	(13,848)	720,217			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	891,820	58,237	281,599	1,231,656		1,231,656	3,882	1,235,538			10
10a	Therapy		4,380	115,193	119,573		119,573		119,573			10a
11	Activities	39,028	1,977	14,040	55,045		55,045		55,045			11
12	Social Services	58,238		4,716	62,954		62,954		62,954			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	989,086	64,594	421,048	1,474,728		1,474,728	3,882	1,478,610			16
	C. General Administration											
17	Administrative	131,571			131,571		131,571		131,571			17
18	Directors Fees											18
19	Professional Services			63,276	63,276		63,276	150	63,426			19
20	Dues, Fees, Subscriptions & Promotions			13,356	13,356		13,356		13,356			20
21	Clerical & General Office Expenses	56,413	26,452	11,033	93,898		93,898	(1,179)	92,719			21
22	Employee Benefits & Payroll Taxes			243,230	243,230		243,230	(4,579)	238,651			22
23	Inservice Training & Education			550	550		550		550			23
24	Travel and Seminar			10,911	10,911		10,911	(3,382)	7,529			24
25	Other Admin. Staff Transportation			4,547	4,547		4,547		4,547			25
26	Insurance-Prop.Liab.Malpractice			59,557	59,557		59,557		59,557			26
27	Other (specify):*											27
28	**TOTAL General Administration**	187,984	26,452	406,460	620,896		620,896	(8,990)	611,906			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,558,107	342,908	928,674	2,829,689		2,829,689	(18,956)	2,810,733			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Medina Nursing Center #0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			67,084	67,084		67,084	12,445	79,529			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,123	4,123		4,123	2,175	6,298			32
33	Real Estate Taxes			38,512	38,512		38,512		38,512			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(36,000)				34
35	Rent-Equipment & Vehicles			12,851	12,851		12,851		12,851			35
36	Other (specify):*											36
37	**TOTAL Ownership**			158,570	158,570		158,570	(21,380)	137,190			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,775	2,620	34,395		34,395		34,395			39
40	Barber and Beauty Shops	10,295	302		10,597		10,597		10,597			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,727	48,727		48,727		48,727			42
43	Other (specify):* Nonallowable Costs			13,184	13,184		13,184	(13,184)				43
44	**TOTAL Special Cost Centers**	10,295	32,077	64,531	106,903		106,903	(13,184)	93,719			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,568,402	374,985	1,151,775	3,095,162		3,095,162	(53,520)	3,041,642			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,966)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,828)	30		9
10	Interest and Other Investment Income	(556)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,162)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(9,162)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,674)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(13,846)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (13,846)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (53,520)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center, Inc.
Provider # 0011551
December 31, 2003

Page 5 **Schedule 5A**

Schedule VI.- Adjustment Detail
Line 29, Other Non-Allowable Expenses

Description	**Amount**	**Sch V line reference**
To Disallow Vending Machine Supply	(6,917)	43
To Disallow Laboratory Expense	(2,851)	43
To Disallow Radiology Expense	(800)	43
To Disallow Insurance	10,546	43
To Disallow Travel & Seminar Expense	(3,382)	24
To offset Uniform Sales	(4,579)	22
To offset Misc Income	(1,179)	21
	(9,162)	

See Accountants' Compilation Report

Medina Nursing Center

ID# 0011551

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,966)	0	0	0	0	0	0	0	0	0	0	(9,966)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,966)	0	0	0	0	0	0	0	0	0	0	(9,966)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	150	0	0	0	0	0	0	0	0	0	150	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	150	0	0	0	0	0	0	0	0	0	150	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,966)	150	0	0	0	0	0	0	0	0	0	(9,816)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Medina Nursing Center # 0011551 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,828)	19,273	0	0	0	0	0	0	0	0	0	12,445	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(556)	2,731	0	0	0	0	0	0	0	0	0	2,175	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,000)	0	0	0	0	0	0	0	0	0	(36,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,384)	(13,996)	0	0	0	0	0	0	0	0	0	(21,380)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(13,162)	0	0	0	0	0	0	0	0	0	0	(13,162)	43
44	**TOTAL Special Cost Centers**	(13,162)	0	0	0	0	0	0	0	0	0	0	(13,162)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,512)	(13,846)	0	0	0	0	0	0	0	0	0	(44,358)	45

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Holgeir J. Oksnevad	100			Medina Manor Building, Inc	Durand	Lessor
				-Owner Johs Oksnevad is the father of Holgeir Oksnevad.		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting Fees	$	Medina Manor Building, Inc.	0.00%	$ 150	$ 150	1
2	V	30	Depreciation		Medina Manor Building, Inc.	0.00%	19,273	19,273	2
3	V	32	Interest		Medina Manor Building, Inc.	0.00%	2,731	2,731	3
4	V	34	Rent	36,000	Medina Manor Building, Inc.	0.00%		(36,000)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 36,000			$ 22,154	$ * (13,846)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Holgeir Oksnevad	President	Administrator	100.00	None	55	100.00	Salary	$ 131,571	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 131,571		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10					N/A					10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	State Bank of Davis		X	Bus Loan	$816.00	06/15/98	$ 40,200	$	06/15/03	0.0825	$ 2,054	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Medina Manor Building	X		Working Capital	None	various	various	12,624	Demand	0.0700	2,731	6
7	Durand State Bank		X	Working Capital	None	12/31/02	50,060		3/31/03	0.0675	936	7
8												8
9	TOTAL Facility Related				$816.00		$ 90,260	$ 12,624			$ 5,721	9
	B. Non-Facility Related*											
10									Miscellaneous Interest		577	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 577	14
15	TOTALS (line 9+line14)						$ 90,260	$ 12,624			$ 6,298	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.		$ 38,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 37,512	2
3. Under or (over) accrual (line 2 minus line 1).		$ (488)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 39,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 38,512	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	32,672	8
	1999	31,868	9
	2000	35,002	10
	2001	36,424	11
	2002	37,512	12
2003 Estimated Tax		37,512	
Estimated Tax Increase		1.03	
		38,637	
Use		39,000	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Medina Nursing Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0011551

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

TELEPHONE (312) 634-4580 FAX #: (312) 634-5518

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-15-251-001	Medina Manor Building	$ 781.86	$ 781.86
2.	05-15-251-002	Medina Manor Building	$ 35,931.56	$ 35,931.56
3.	05-15-251-003	Medina Manor Building	$ 799.04	$ 799.04
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 37,512.46	$ 37,512.46

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,000 B. General Construction Type: Exterior Brick Frame Masonry, Fire Resistar Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Medina Manor Apartments
-Retirement Apartments
-22 units
- 20,000 Sq. ft

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	7 acres	1965	$ 3,048	1
2					2
3	TOTALS			$ 3,048	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1965	1965	$ 488,644	$	30	$	$	$ 488,644	4
5	25		1980	1980	158,173		30	5,272	5,272	126,689	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1968	675		15			675	9
10	Building Improvements			1974	861		10			861	10
11	Building Improvements			1975	1,547		10			1,547	11
12	Building Improvements			1976	345		9			345	12
13	Building Improvements			1977	12,614		21			12,614	13
14	Building Improvements			1977	2,793		8			2,793	14
15	Building Improvements			1979	2,620		7			2,620	15
16	Building Improvements			1980	24,465		20			24,465	16
17	Building Improvements			1980	2,137		7			2,137	17
18	Building Improvements			1981	20,211		15			20,211	18
19	Building Improvements			1982	2,305		20			2,305	19
20	Building Improvements			1983	705		5			705	20
21	Building Improvements			1985	980		10			980	21
22	Building Improvements			1985	3,091	103	20	155	52	2,864	22
23	Building Improvements			1986	17,543		10			17,543	23
24	Building Improvements			1987	56,373		20	2,819	2,819	46,504	24
25	Building Improvements			1988	14,212	950	20	711	(239)	11,013	25
26	Building Improvements			1989	30,063	2,004	20	1,503	(501)	21,795	26
27	Building Improvements			1990	1,601	107	20	80	(27)	1,084	27
28	Building Improvements			1991	51,619	3,441	20	2,581	(860)	32,262	28
29	Building Improvements			1991	11,626		20	581	581	6,684	29
30	Building Improvements			1992	39,070	2,605	20	1,954	(651)	20,515	30
31	Building Improvements			1992	3,295	203	20	165	(38)	1,895	31
32	Building Improvements			1992	19,372		20	969	969	11,141	32
33	Building Improvements			1992	23,809	2,362	20	1,190	(1,172)	13,685	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements	1993	$ 37,059	$ 2,471	20	$ 1,853	$ (618)	$ 19,459	37
38	Building Improvements	1993	100,000		20	5,000	5,000	51,669	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	25,604	39
40	Building Improvements	1994	15,610		10	1,561	1,561	14,049	40
41	Building Improvements	1995	47,826	3,188	15	3,188		27,099	41
42	Building Improvements	1995	36,144	2,410	15	2,410		20,484	42
43	Outdoor Signs	1996	2,149	143	15	143		1,073	43
44	Backflow Preventors	1996	3,679	245	15	245		1,838	44
45	Garbage Disposal	1996	761	51	15	51		382	45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		1,098	46
47	Door	1997	1,996	133	15	133		865	47
48	Sign	1997	666	44	15	44		287	48
49	Air Conditioner	1997	3,500	233	15	233		1,515	49
50	Lights	1997	621	41	15	41		267	50
51	Driveway	1997	2,875	192	15	192		1,248	51
52	Fire Alarm	1997	1,246	83	15	83		540	52
53	Plumbing	1997	5,122	341	15	341		2,217	53
54	Telephone System	1997	1,152	77	15	77		476	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		254	55
56	Office Remodeling	1998	2,454	164	15	164		902	56
57	Exterior Doors	1998	7,652	510	15	510		2,805	57
58	Windows	1998	15,536	1,036	15	1,036		5,698	58
59	Roof Repair	1998	2,317	154	15	154		847	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		1,159	60
61	Fire Alarm	1998	1,157	77	15	77		424	61
62	Telephone System	1998	1,467	98	15	98		537	62
63	Time Clock System	1998	8,238	549	15	549		3,021	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,350,158	$ 27,650		$ 39,277	$ 11,627	$ 1,060,393	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,350,158	$ 27,650		$ 39,277	$ 11,627	$ 1,060,393	1
2	Blinds	1999	3,689	246	15	246		1,105	2
3	Window Replacement	1999	5,145	305	15	343	38	1,544	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	521	40	2,345	4
5	Floor Tile	1999	1,049	70	15	70		315	5
6	Air Conditioning	1999	1,895	126	15	126		567	6
7	Boiler	1999	535	35	15	35		158	7
8	Sidewalk	2000	1,386	92	15	92		322	8
9	Kickplates	2000	608	40	15	40		140	9
10	Landscaping Brick	2000	1,139	76	15	76		266	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		2,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		275	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		617	13
14	Stone Wall	2001	1,665	111	15	111		277	14
15	Video Surveillance	2002	14,865	991	15	991		1,487	15
16	Wrought Iron Fence	2002	5,105	340	15	340		510	16
17	Nurses Call System	2002	12,726	848	15	848		1,272	17
18	Custom Doors	2002	9,427	628	15	628		942	18
19	Windows Framing	2003	11,656	389	15	389		389	19
20	Roof	2003	7,470	249	15	249		249	20
21	Alarm Installation	2003	12,730	424	15	424		424	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,469,422	$ 34,458		$ 46,163	$ 11,705	$ 1,076,097	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 217,416	$ 22,385	$ 23,125	$ 740	10 Years	$ 143,815	71
72	Current Year Purchases	7,878	634	634		10 Years	634	72
73	Fully Depreciated Assets	20,975					20,975	73
74								74
75	TOTALS	$ 246,269	$ 23,019	$ 23,759	$ 740		$ 165,424	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Activity Bus	1975 Ford Bus	1985	$ 9,409	$	$	$	3	$ 9,409	76
77	Resident Van	1991 Chevy Lumina	1991	18,008				3	18,008	77
78	Activity Bus	1998 Ford Bus	1998	49,705				5	49,705	78
79	From Page 13A			57,763	9,607	9,607		5	24,866	79
80	TOTALS			$ 134,885	$ 9,607	$ 9,607	$		$ 101,988	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,853,624	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 67,084	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 79,529	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,445	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,343,509	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$ 0		$	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 0	$ 0	$ 0	$ 0		$ 0	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	1997 Dodge Pickup	2000	$ 23,705	$ 4,741	$ 4,741	$ 0	5	16,594	76
77	Administrative	2002 Jeep Liberty	2002	30,000	4,286	4,286	0	5	7,286	77
78	Administrative	2000 Dodge Caravan	2002	4,058	580	580	0	5	986	78
79							0			79
80	TOTALS			$ 57,763	$ 9,607	$ 9,607	$ 0		$ 24,866	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5					N/A			5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2000 BMW	$ 984.97	$ 12,851	17
18					18
19					19
20					20
21	TOTAL		$ 984.97	$ 12,851	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	1,604	$ 49,715	$	1,604	$ 49,715	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		486	14,556		486	14,556	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2 & C3	hrs		992	50,922	4,380	992	55,302	4
5	Physician Care		visits							5
6	Dental Care	L39, C3	visits			2,620			2,620	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				31,775		31,775	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	3,082	$ 117,813	$ 36,155	3,082	$ 153,968	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 54,414	$ 54,668	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	471,394	471,394	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,664	16,664	6
7	Other Prepaid Expenses	34,896	36,130	7
8	Accounts Receivable (owners or related parties)	18,000	18,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 595,368	$ 596,856	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,816	14
15	Leasehold Improvements, at Historical Cost	612,489	822,606	15
16	Equipment, at Historical Cost	515,139	381,154	16
17	Accumulated Depreciation (book methods)	(770,915)	(1,343,509)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Life Insurance Cash Value	51,996	51,996	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 408,709	$ 562,111	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,004,077	$ 1,158,967	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 49,018	$ 49,018	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		12,624	29
30	Accrued Salaries Payable	90,543	90,543	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,746	30,746	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,000	39,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	4,661	4,661	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 213,968	$ 226,592	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 213,968	$ 226,592	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 790,109	$ 932,375	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,004,077	$ 1,158,967	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Medina Nursing Center, Inc.
Provider # 0011551
December 31, 2003

Page 17 **Schedule 17A**
Schedule XV.
Balance Sheet

Line 36 - Other Current Liabilities

	Operating	After Consolidation
Miscellaneous Current Liabilities	1,566	1,566
Due to Related Party	3,095	3,095
Total	4,661	4,661

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 767,962	1
2	Restatements (describe):		2
3	**Additional Adjustments**	(62,364)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 705,598	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	143,762	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(59,251)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 84,511	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 790,109	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,869,301	1
2	Discounts and Allowances for all Levels	43,989	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,913,290	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	219,641	6
7	Oxygen	3,846	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 223,487	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,302	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31,528	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	961	19
20	Radiology and X-Ray	173	20
21	Other Medical Services	34,251	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 75,215	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	556	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 556	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous income**	935	28
28a	**See Schedule 19A**	25,441	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,376	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,238,924	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	734,065	31
32	Health Care	1,474,728	32
33	General Administration	620,896	33
	B. Capital Expense		
34	Ownership	158,570	34
	C. Ancillary Expense		
35	Special Cost Centers	58,176	35
36	Provider Participation Fee	48,727	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,095,162	40
41	**Income before Income Taxes (line 30 minus line 40)****	143,762	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 143,762	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis tax payer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Medina Nursing Center, Inc.
Provider # 0011551
12/31/2003

Page 19 **Schedule 19A**
Schedule XVII
Income Statement

Line 28a - Other Revenue (specify):

	Amount
Vending Machine Income	10,652
Food Purchased	4,574
Office Sales	244
Uniform Sales	4,579
Meal Sales	5,392
Total	25,441

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,616	1,696	$ 42,724	$ 25.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,909	4,417	96,928	21.94	3
4	Licensed Practical Nurses	6,814	7,360	121,614	16.52	4
5	Nurse Aides & Orderlies	51,965	54,138	539,367	9.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,477	1,638	16,758	10.23	9
10	Activity Assistants	2,869	3,018	22,270	7.38	10
11	Social Service Workers	3,852	4,142	58,238	14.06	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	28,733	13.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,094	22,160	170,389	7.69	15
16	Dishwashers					16
17	Maintenance Workers	4,364	4,632	44,856	9.68	17
18	Housekeepers	7,226	7,775	71,676	9.22	18
19	Laundry	7,784	8,294	65,383	7.88	19
20	Administrator	2,740	2,860	131,571	46.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,252	4,436	56,413	12.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,663	1,765	15,839	8.97	31
32	Other Health Ca Care Plan Coord	3,752	4,085	75,348	18.45	32
33	Other(specify) Barber & Beauty	998	1,091	10,295	9.44	33
34	TOTAL (lines 1 - 33)	128,375	135,587	$ 1,568,402 *	$ 11.57	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	115	$ 5,388	L1, C3	35
36	Medical Director	Monthly	5,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	931	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	1,035	L11, C3	44
45	Social Service Consultant	11	820	L12, C3	45
46	Other(specify)				46
47	Physical Rehab Consulting	Monthly	300	L10, C3	47
48	Occupational Rehab Consulting	52	2,313	L10, C3	48
49	TOTAL (lines 35 - 48)	191	$ 16,286		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,301	$ 87,842	L10, C3	50
51	Licensed Practical Nurses	3,009	100,217	L10, C3	51
52	Nurse Aides	4,582	89,996	L10, C3	52
53	TOTAL (lines 50 - 52)	9,892	$ 278,055		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Holgeir Oksnevad	Administrator	100	$ 131,571
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,571

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 19,949
American Express Tax &		
Business Service	Accounting	6,225
Duane Morris LLP	Legal	16,051
Tim Sisneros	Computer Consultant	1,500
Achieve Software	Computer	7,764
Mutual of Omaha	Computer	54
Main St. Web Design	Computer	595
Computer Education	Computer	1,707
Information Control	Computer	1,233
Mediacom	Computer	300
Business Management	Computer	7,898
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 63,276

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,613
Unemployment Compensation Insurance	11,064
FICA Taxes	116,753
Employee Health Insurance	50,755
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,595
401(K) Plan	6,668
Employee Goodwill	5,222
Uniforms	981
TOTAL (agree to Schedule V, line 22, col.8)	$ 238,651

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,756
Health Care Worker Background Check	
(Indicate # of checks performed 40)	576
Illinois Health Care Association	4,806
Secretary of State	481
Miscellaneous Dues & Subscriptions	1,200
Miscellaneous License & Fees	337
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,356

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,427
Seminar Expense	4,102
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,529

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center
Provider #: 0011551
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	63,276
Allocated from Management Company	150
Total (agree to Schedule V, line 19, column 8)	63,426

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9								N/A					
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $4806**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **3,882** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **48,727**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **5,392**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Medina Nursing Center** **12:37 PM** **11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CELL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-53,520	equal to	-53,520	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	6,298	equal to	6,298	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	38,512	equal to	38,512	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	79,529	equal to	79,529	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	12,851	equal to	12,851	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	119,573	equal to	119,573	0	O.K.	Pg16 Z12+Z14..Z1	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	36,155	equal to	36,155	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	734,065	equal to	734,065	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,474,728	equal to	1,474,728	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	620,896	equal to	620,896	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	158,570	equal to	158,570	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	58,176	equal to	58,176	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	48,727	equal to	48,727	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	816,472	equal to	891,820	-75,348	FAILED	Pg20 K11..K15+K:	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	39,028	equal to	39,028	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	58,238	equal to	58,238	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	199,122	equal to	199,122	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	44,856	equal to	44,856	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	71,676	equal to	71,676	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	65,383	equal to	65,383	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	131,571	equal to	131,571	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	56,413	equal to	56,413	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,568,402	equal to	1,568,402	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,388	< or = to	5,505	-117	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	5,500	< or = to	5,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	278,986	< or = to	281,599	-2,613	O.K.	Pg20 X14..X16+X:	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,035	< or = to	14,040	-13,005	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	820	< or = to	4,716	-3,896	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	131,571	equal to	131,571	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	63,276	equal to	63,276	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	238,651	equal to	238,651	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	13,356	equal to	13,356	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	7,529	equal to	7,529	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	48,727	equal to	48,727	-1	FAILED	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	-4,579	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,608	equal to	1,608	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-13,846	equal to	-13,846	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4(	B.	14	8
Total loan balance	12,624	equal to	12,624	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	39,000	equal to	39,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	3,048	equal to	3,048	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,469,422	equal to	1,469,422	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	381,154	equal to	381,154	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,343,509	equal to	1,343,509	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	790,109	equal to	790,109	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	143,762	equal to	143,762	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S3	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,004,077	equal to	1,004,077	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses

YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK TO THE COST REPORT!! 11/4/2005 12:37:00 PM

HSA Number	1	Name	Medina Nursing Center			
Cost report period	From:	01/01/03	To:	12/31/03	Base Number	336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N				
Licensed bed days:	32,485	Occupancy:	28,487	Pct. of occupancy:	87.69%	
Illinois Public Aid Support Rate		$				
Genl Services Salary/Wage:	381,037	Col 1, Line 8 ---Audit Adj:				
Genl Admin Salary/Wage	187,984	Col 1, Line 28 ---Audit Adj:	-61571			
Total Salary Wage	1,568,402	Col 1, Line 44 ---Audit Adj:	-61571			
Employee Benefits	238,651	Col 8, Line 22 ---Audit Adj:				
Total General Services:	720,217	Col 8, Line 8 ---Audit Adj:				
Total General Admin	611,906	Col 8, Line 28 ---Audit Adj:	-61571			

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$381,037
Divided by Total Wages (Column 1, Line 44	$1,506,831
General service wages as percent of total wages	25.2873%
Employee Benefits (Column 10, Line 22	$238,651
Allocation of Employee Benefits to General Services Costs	$60,348
Plus Total General Services (Column 10, Line 8	$720,217
New Total General Services Cost	$780,565

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by the proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$126,413
Divided by Total Wages (Column 1, Line 45	$1,506,831
General administration wages as a percent of total wages	8.3893%
Employee Benefits (Column 10, Line 22	$238,651
Allocation of Emplayee Benefits to General Admin. Cost	$20,021
Plus Total General Administration (Column 10, Line 2	$550,335
Minus Total Fringe (Column 10, Line 2:	$238,651
New Total General Administration Cos	$331,705

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$780,565	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$780,565

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$331,705	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$331,705
3 Total Updated Support Costs (1 + 2		$1,112,270

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $38.27

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$1,112,270
Total Patient Days (Cost Report	28,487
Support Costs per Diem	$39.04

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	32,485
Multiplied by	0.93
	30,211
Minus total Patient Day	28,487
	1,724
One-third of difference	575
Plus Total Patient Day	28,487
Adjusted Occupancy	29,062
Total Support Costs (Step II, C, 3, above	$1,112,270
Divided by Adjusted Occupany	29062
Support Costs Per Dien	$38.27

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$40.08
Minus Support Costs Per Dier	$38.27
Difference	$1.81
Multiply the Difference by	0.5
One-Half of the Difference	$0.90
Plus Support Costs Per Dier	$38.27
Support Rate if costs are between 35th and 75th percentile	39.17

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$40.08
Minus Support Costs Per Dier	$38.27
Difference	$1.81
Multiply the Difference by	0.5
One-Half of the Difference	$0.90
Compare one-half the difference to the profit ceiling for your HSA in Table II anc	4.04
Enter the Lower of the Two Amounts	$0.900
Plus Support Costs Per Dier	$38.27
Support Rate if support costs less than 35th percentile	$39.17

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **$39.17**

75th Percentile is	$40.08
35th Percentile is	$32.10

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED
TO THE COST REPORT!!!! 11/4/2005 12:37:00 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Medina Nursing Center** ID: **0011551**

HSA No.: 1 Own or Rent? (O or R) R Own or Rent Beginning: 5/18/1965

IF RENTED, have facilities been continously rented
from an unrelated party since prior to January 1, 1978 (Y or N): N
or since the first day of operation for buildings
constructed since January 1, 1978?

Cost Report Pd:		Licensed Beds:	89	Total Patient Days	28,487
Begin	**01/01/03**	Licensed Bed Days:	32,485	% Occupied	87.69%
End	**12/31/03**			Capital Days	30,211

1989 Property Tax COST: ________ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ________ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ________ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1982
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	1469422
2. Total licensed beds from cost report Page 2, Line 7, column 3	89
3. Line 1 divided by Line 2	$16,510
4. Regional construction inflator from Table 2	1.67
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	27572
C. Obtain the Uniform Building Value from Table 1	17324
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	27572
2. Uniform building value from Line C	17324
3. Add Lines 1 and 2	44896
4. Divide by 2 to obtain average	22448
5. Enter 120% of line C	20789
6. The blended value is the lesser of Line 4 or Line 5	20789
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	61.3245
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	6.75
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	9.25
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0
J. Property Tax Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:	
1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	30,211
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	1.05723
5. Equals: Updated Property Tax Cost	0
Capital Days The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)	
1. Total Patient Days	28,487
2. Total Licensed Bed Days * .93	30211
3. Capital Days (higher of Line 1 or Line 2)	30,211
K. Total Capital Rate for FY 94	
1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	9.25
2. Add Property Tax from Line J5	0
3. Total capital rate (add Lines 1 & 2)	9.25

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	65	488644	31761860	12
2	2	80	158173	12653840	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	68	675	45900	12
7	7	74	861	63714	12
8	8	75	1547	116025	12
9	9	76	345	26220	12
10	10	77	12614	971278	12
11	11	77	2793	215061	12
12	12	79	2620	206980	12
13	13	80	24465	1957200	12
14	14	80	2137	170960	12
15	15	81	20211	1637091	12
16	16	82	2305	189010	12
17	17	83	705	58515	12
18	18	85	980	83300	12
19	19	85	3091	262735	12
20	20	86	17543	1508698	12
21	21	87	56373	4904451	12
22	22	88	14212	1250656	12
23	23	89	30063	2675607	12
24	24	90	1601	144090	12
25	25	91	51619	4697329	12
26	26	91	11626	1057966	12
27	27	92	39070	3594440	12
28	28	92	3295	303140	12
29	29	92	19372	1782224	12
30	30	92	23809	2190428	12
31	31	0	0	0	12
32	32	0	0	0	12
33	33	0	0	0	12
34	34	93	37059	3446487	12A
35	35	93	100000	9300000	12A
36	36	94	53900	5066600	12A
37	37	94	15610	1467340	12A
38	38	95	47826	4543470	12A
39	39	95	36144	3433680	12A
40	40	96	2149	206304	12A
41	41	96	3679	353184	12A
42	42	96	761	73056	12A
43	43	97	2532	245604	12A
44	44	97	1996	193612	12A
45	45	97	666	64602	12A
46	46	97	3500	339500	12A
47	47	97	621	60237	12A
48	48	97	2875	278875	12A
49	49	97	1246	120862	12A
50	50	97	5122	496834	12A
51	51	97	1152	111744	12A
52	52	97	585	56745	12A
53	53	98	2454	240492	12A
54	54	98	7652	749896	12A
55	55	98	15536	1522528	12A
56	56	98	2317	227066	12A
57	57	98	3165	310170	12A
58	58	98	1157	113386	12A
59	59	98	1467	143766	12A
60	60	98	8238	807324	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	99	3689	365211	12B
68	68	99	5145	509355	12B
69	69	99	7824	774576	12B
70	70	99	1049	103851	12B
71	71	99	1895	187605	12B
72	72	99	535	52965	12B
73	73	100	1386	138600	12B
74	74	100	608	60800	12B
75	75	100	1139	113900	12B
76	76	101	15000	1515000	12B
77	77	101	1650	166650	12B
78	78	101	3700	373700	12B
79	79	101	1665	168165	12B
80	80	102	14865	1516230	12B
81	81	102	5105	520710	12B
82	82	102	12726	1298052	12B
83	83	102	9427	961554	12B
84	84	103	11656	1200568	12B
85	85	103	7470	769410	12B
86	86	103	12730	1311190	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
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135	0	0	0	12D
136	0	0	0	12D
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143	0	0	0	12D
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154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

120610174 1469422 82.08001105

Base Year = 1982

TABLE 1 2

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 1

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	199,122	25,722	5,505	230,349	0	230,349	0	230,349
2. Food Purchase	0	179,736	0	179,736	0	179,736	-9,966	169,770
3. Housekeeping	71,676	19,919	0	91,595	0	91,595	0	91,595
4. Laundry	65,383	14,350	0	79,733	0	79,733	-3,882	75,851
5. Heat and Other Utilities	0	0	67,734	67,734	0	67,734	0	67,734
6. Maintenance	44,856	12,135	27,927	84,918	0	84,918	0	84,918
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	381,037	251,862	101,166	734,065	0	734,065	-13,848	720,217
9. Medical Director	0	0	5,500	5,500	0	5,500	0	5,500
10. Nursing & Medical Records	891,820	58,237	281,599	1,231,656	0	1,231,656	3,882	1,235,538
10a. Therapy	0	4,380	115,193	119,573	0	119,573	0	119,573
11. Activities	39,028	1,977	14,040	55,045	0	55,045	0	55,045
12. Social Services	58,238	0	4,716	62,954	0	62,954	0	62,954
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	989,086	64,594	421,048	1,474,728	0	1,474,728	3,882	1,478,610
17. Administrative	131,571	0	0	131,571	0	131,571	0	131,571
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	63,276	63,276	0	63,276	150	63,426
20. Fees, Subscriptions & Promotion	0	0	13,356	13,356	0	13,356	0	13,356
21. Clerical & General Office	56,413	26,452	11,033	93,898	0	93,898	-1,179	92,719
22. Employee Benefits & Payroll	0	0	243,230	243,230	0	243,230	-4,579	238,651
23. Inservice Training & Education	0	0	550	550	0	550	0	550
24. Travel and Seminar	0	0	10,911	10,911	0	10,911	-3,382	7,529
25. Other Admin. Staff Trans	0	0	4,547	4,547	0	4,547	0	4,547
26. Insurance-Prop.Liab.Malpractice	0	0	59,557	59,557	0	59,557	0	59,557
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	187,984	26,452	406,460	620,896	0	620,896	-8,990	611,906
29. Total General Administrative	1,558,107	342,908	928,674	2,829,689	0	2,829,689	-18,956	2,810,733
30. Depreciation	0	0	67,084	67,084	0	67,084	12,445	79,529
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	4,123	4,123	0	4,123	2,175	6,298
33. Real Estate	0	0	38,512	38,512	0	38,512	0	38,512
34. Rent - Facility & Grounds	0	0	36,000	36,000	0	36,000	-36,000	0
35. Rent - Equipment & Vehicles	0	0	12,851	12,851	0	12,851	0	12,851
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	158,570	158,570	0	158,570	-21,380	137,190
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	31,775	2,620	34,395	0	34,395	0	34,395
40. Barber and Beauty Shop	10,295	302	0	10,597	0	10,597	0	10,597
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	48,727	48,727	0	48,727	0	48,727
43. Other (specify):*	0	0	13,184	13,184	0	13,184	-13,184	0
44. Total Special Cost Ce	10,295	32,077	64,531	106,903	0	106,903	-13,184	93,719
45. Grand Total	1,568,402	374,985	1,151,775	3,095,162	0	3,095,162	-53,520	3,041,642

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	54,414	54,668
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	471,394	471,394
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	16,664	16,664
7. Other Prepaid Expenses	34,896	36,130
8. Accounts Receivable-Owner/Related Party	18,000	18,000
9. Other (specify):	0	0
10. Total current assets	595,368	596,856
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	3,048
14. Buildings, at Historical Cost	0	646,816
15. Leasehold Improvements, Historical Cost	612,489	822,606
16. Equipment, at Historical Cost	515,139	381,154
17. Accumulated Depreciation (book methods)	-770,915	-1,343,509
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	51,996	51,996
24. Total Long-Term Assets	408,709	562,111
25. Total Assets	1,004,077	1,158,967
CURRENT LIABILITIES		
26. Accounts Payable	49,018	49,018
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	12,624
30. Accrued Salaries Payable	90,543	90,543
31. Accrued Taxes Payable	30,746	30,746
32. Accrued Real Estate Taxes	39,000	39,000
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	4,661	4,661
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	213,968	226,592
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	213,968	226,592
47.Total Equity	790,109	932,375
48.Total Liabilities and Equity	1,004,077	1,158,967

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,869,301
2. Discounts and Allowances for all Levels	43,989
Subtotal - Inpatient Care	2,913,290
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	219,641
7. Oxygen	3,846
Subtotal - Anciliary Revenue	223,487
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	8,302
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	31,528
18. Sale of Supplies to Non-Patients	0
19. Laboratory	961
20. Radiologyand X-Ray	173
21. Other Medical Services	34,251
22. Laundry	0
Subtotal - Other Operating Revenue	75,215
24. Contributions	0
25. Interest and Other Investments Income	556
Subtotal - Non-Operating Revenue	556
27. Other Revenue (specify):	935
28. Other Revenue (specify):	25,441
Subtotal - Other Revenue	26,376
30. Total Revenue	3,238,924
31. General Services	734,065
32. Health Care	1,474,728
33. General Administration	620,896
34. Ownership	158,570
35. Special Cost Centers	58,176
35. Provider Participation Fee	48,727
37. Other	0
40. Total Expenses	3,095,162
41. Income Before Income Taxes	143,762
42. Income Taxes	0
43. Net Income or Loss for the Year	143,762

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23	Provider Participation fee is linked from page 4